

Unannounced Medicines Management Inspection Report 4 February 2019



Killynure House

Type of service: Residential Care Home

Address: 26 Church Road, Carryduff, BT8 8DT

Tel No: 028 9504 2960

Inspector: Catherine Glover

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for



2.0 Profile of service

This is a residential care home that provides care for up to 40 residents with a diagnosis of dementia.

3.0 Service details

Organisation/Registered Provider: Belfast HSC Trust Responsible Individual: Mr Martin Joseph Dillon	Registered Manager: See Below
Person in charge at the time of inspection: Ms Diane McGann, Senior Care Assistant	Date manager registered: Ms Julie Grimes - acting manager - no application.
Categories of care: Residential Care (RC) DE – Dementia.	Number of registered places: 40 The home is approved to provide care on a day basis only to 2 persons in DE category of care Monday to Sunday inclusive

4.0 Inspection summary

An unannounced inspection took place on 4 February 2019 from 10.30 to 12.30.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Residential Care Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011).

The inspection assessed progress with any areas for improvement identified since the last medicines management inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to medicines administration, medicine records, storage and the management of controlled drugs.

No areas for improvement were identified.

Residents said that they were happy and content living in the home and that the staff were good.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and residents' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Ms Diane McGann, Senior Care Assistant, as part of the inspection process and can be found in the main body of the report.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent care inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 15 August 2018. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the home was reviewed. This included the following:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the management of medicine related incidents reported to RQIA since the last medicines management inspection.

During the inspection we met with four residents, one resident's family and two senior care assistants.

We provided the senior care assistant with ten questionnaires to distribute to residents and their representatives, for completion and return to RQIA. 'Have we missed you?' cards were left in the foyer of the home to inform residents/their representatives of how to contact RQIA, to tell us of their experience of the quality of care provided. Flyers providing details of how to raise any concerns were also left in the home. Staff were invited to share their views by completing an online questionnaire.

A poster informing visitors to the home that an inspection was being conducted was displayed.

A sample of the following records was examined during the inspection:

- medicines requested and received
- personal medication records
- medicine administration records
- medicines disposed of or transferred
- controlled drug record book
- medicine audits
- care plans
- training records
- medicines storage temperatures

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 15 August 2018

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned to the care inspector. This QIP will be validated by the care inspector at the next care inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 14 July 2016

There were no areas for improvement identified as a result of the last medicines management inspection.

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

Medicines were managed by staff who have been trained and deemed competent to do so. The impact of training was monitored through team meetings, supervision and annual appraisal. Refresher training in medicines management was provided every three years. In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Staff advised of the procedures to identify and report any potential shortfalls in medicines.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records were updated by two members of staff. This safe practice was acknowledged. Staff were reminded that adhesive labels should not be used on the medicine administration sheets and that hand-written updates should be signed by two staff members.

There were procedures in place to ensure the safe management of medicines during a resident's admission to the home.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. Checks were performed on controlled drugs which require safe custody, at the end of each shift. Additional checks were also performed on other controlled drugs which is good practice.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin. The use of separate administration charts was acknowledged.

Discontinued or expired medicines were disposed of appropriately.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. The medicine refrigerator was checked at regular intervals.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment, the management of medicines on admission, controlled drugs and the storage of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

The sample of medicines examined had been administered in accordance with the prescriber's instructions. There was evidence that time critical medicines had been administered at the correct time. There were arrangements in place to alert staff of when doses of weekly, monthly or three monthly medicines were due.

The management of distressed reactions and pain was examined. All of the appropriate records and assessments had been completed. Care plans were in place and administration records were completed appropriately.

Staff confirmed that compliance with prescribed medicine regimes was monitored and any omissions or refusals likely to have an adverse effect on the resident's health were reported to the prescriber.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included additional monitoring of analgesics.

Practices for the management of medicines were audited throughout the month by the staff and management.

Following discussion with the staff and examination of care records, it was evident that other healthcare professionals are contacted when required to meet the needs of residents.

Areas of good practice

There were examples of good practice in relation to the standard of record keeping, care planning and the administration of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

The administration of medicines to residents was not observed during this inspection, however the senior care assistant was knowledgeable about the residents' medicines and medical requirements.

It was found that there were good relationships between the staff and the residents. Staff were noted to be friendly and courteous; they treated the residents with dignity. It was clear from discussion and observation of staff, that the staff were familiar with the residents' likes and dislikes.

We spoke with four residents. They were relaxed and comfortable in the home and said that they were content with their stay. They said that the staff were good, they enjoyed the food and their rooms were comfortable.

We spoke to one resident's family who were visiting at the time of the inspection. They said that they were very happy with the care provided, the staff were excellent and that their relative was very content in the home. They said that they felt very welcome in the home and communication with staff was good.

Two questionnaires that were issued to residents/relatives were returned. All responses indicated that residents were very satisfied with the care in the home. Comments included:

"Senior staff are very quick to act if they or family think there is something wrong with a resident."

"More activities are needed for the residents."

Areas of good practice

Staff listened to residents and took account of their views.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

Written policies and procedures for the management of medicines were in place. They were not reviewed on this occasion. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding team.

A review of the audit records indicated that satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was evidence of the action taken and learning which had resulted in a change of practice.

Following discussion with the care staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

Staff confirmed that any concerns in relation to medicines management were raised with management.

There were no responses to the online staff questionnaire.

Areas of good practice

There were examples of good practice in relation to governance arrangements, the management of medicine incidents and quality improvement. There were clearly defined roles and responsibilities for staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.



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